**TJ REGIONAL HEALTH SCHOOL-BASED MEDICINE PROGRAM**

**PRIMARY CARE PROVIDER (PCP) AUTHORIZATION: SEIZURES**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLASSROOM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOSPITAL OF CHOICE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TYPE OF SEIZURE:**

\_\_\_\_ TONIC-CLONIC (GRAND MAL)

\_\_\_\_ ABSENCE (PETIT MAL)

\_\_\_\_ SIMPLE PARTIAL

\_\_\_\_ COMPLEX PARTIAL

OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE SPECIFY LIKELY CHARACTERISTICS:**

DURATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AURA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EXTREMITIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EYES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOUTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BREATHING: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONSCIOUSNESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOES STUDENT HAVE VAGAL NERVE STIMULATOR?** \_\_\_\_ YES\_\_\_\_ NO

VNS MAGNET SHOULD BE KEPT WITH STUDENT AT ALL TIMES. IF CHILD HAS VNS, PLEASE SPECIFY WHEN TO USE & HOW OFTEN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOES THE STUDENT HAVE DIASTAT?** \_\_\_ YES \_\_\_ NO

**IF YES, PLEASE SPECIFY:**

DOSE \_\_\_\_\_\_\_\_MG PER RECTUM & ADMINISTER AT: \_\_\_\_\_ ONSET OF SEIZURE \_\_\_\_\_ MINUTES AFTER ONSET OF SEIZURE.

DIASTAT WILL BE KEPT: \_\_\_\_\_FRONT OFFICE \_\_\_\_\_ NURSE’S OFFICE \_\_\_\_\_ IN CLASSROOM WITH TRAINED ADULT

**DOES THE CHILD TAKE ORAL/G-TUBE/NASAL SEIZURE MEDICATIONS?** \_\_\_ YES \_\_\_ NO

**IF YES, PLEASE SPECIFY:**

\_\_\_\_ G-TUBE FOR MEDS \_\_\_\_GIVE MEDS ORALLY \_\_\_\_ GIVE MEDS NASAL

**EMEREGENCY PLAN OF ACTION:**

1. TIME OF SEIZURE
2. EASE THE STUDENT TO THE FLOOR, REMOVE HAZARDS IN THE AREA, & TURN STUDENT ON THEIR SIDE TO KEEP AIRWAY OPEN.
3. USE VNS &/OR RECTAL DIASTAT AS INDICATED.
4. CALL 911 IF: DIASTAT IS ADMINISTERED, IF ANY SEIZURE LASTS LONGER THAN 5 MINUTES, IF THERE IS ANY CONTINUED OR PROGRESSIVE RESPIRATORY DISTRESS, IF ANOTHER SEIZURE STARTS RIGHT AFTER THE FIRST ONE, IF THE SCHOOL HAS NO RECORD OF STUDENT HISTORY OF SEIZURES, OR IF THE PCP FORM INDICATES TO CALL AT ONSET OF SEIZURE.
5. IF DIASTAT IS ADMINISTERED & A NURSE IS AVAILABLE IN THE BUILDING TO MONITOR THE STUDENT, THE NURSE MAY OBSERVE THE STUDENT UNTIL PARENT/GUARDIAN ARRIVES.
6. NOTIFY SCHOOL PERSONNEL THAT IS TRAINED IN CPR/FIRST AID TO RESPOND IF NEEDED PRIOR TO EMS ARRIVAL.
7. NOTIFY PARENT/GUARDIAN.
8. IF EMS IS CALLED, THE STUDENT MUST BE TRANSPORTED VIA EMS TO EMERGENCY FACILITY UNLESS THE PARENT/GUARDIAN SIGNS A RELEASE WITH EMS & THEN ASSUMES RESPONSIBILITY FOR THE STUDENT. THE STUDENT MAY NOT RETURN TO SCHOOL THAT DAY. IF THE STUDENT IS TRANSPORTED VIA EMS, STAFF WILL ACCOMPANY THE STUDENT UNLESS PARENT/GUARDIAN ACCOMPANIES THEM.
9. DOCUMENT ALL SEIZURE ACTIVITY.
10. IF THE STUDENT REQUIRES MEDICAL TREATMENT WHILE ON THE BUS, THE DRIVER WILL CONTACT 911.

**THIS ORDER & CARE PLAN IS FOR THE CURRENT SCHOOL YEAR. PARENT/GUARDIAN WILL SUPPLY ALL MEDICATIONS.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRINTED NAME OF PROVIDER PHONE NUMBER DATE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE OF PROVIDER FAX NUMBER**

**ADDRESS OF PROVIDER**

**I GIVE PERMISSION FOR (STUDENT NAME) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO RECEIVE THE ABOVE STATED MEDICATION AT SCHOOL ACCORDING TO THE STANDARD SCHOOL POLICY. I RELEASE THE METCALFE COUNTY SCHOOL DISTRICT, TJRH & ITS NURSES FROM ANY CLAIMS OR LIABILITY CONNECTED WITH ITS RELIANCE ON THIS PERMISSION. (PARENT/GUARDIAN TO BRING MEDICATION IN ORIGINAL CONTAINER).**

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**PARENT/GUARDIAN SIGNATURE PHONE NUMBER DATE**

REVIEWED BY SCHOOL NURSE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_